Senate Bill No. 1531

CHAPTER 555

An act to amend Sections 1358.11 and 1358.12 of the Health and Safety Code, and to amend Sections 10192.11 and 10192.12 of the Insurance Code, relating to health care coverage.

[Approved by Governor September 14, 2002. Filed with Secretary of State September 15, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1531, Speier. Health care coverage.

Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and for the regulation of health insurers by the Department of Insurance. Under existing law, a violation of the provisions governing health care service plans is punishable as a crime.

Existing law requires a plan and a health insurer to issue a Medicare supplement policy on a guaranteed basis to specified individuals, including those enrolled in a Medicare+Choice plan, who satisfy designated criteria. Under existing federal law provisions regulating those plans, a Medicare+Choice organization may apply to the United States Department of Health and Human Services Centers for Medicare and Medicaid Services for a modification of a service area of a Medicare+Choice plan that it offers. Existing law additionally provides that a plan and a health insurer may not deny, condition the offering or effectiveness of, or discriminate in the pricing of a Medicare supplement policy or contract because of, among other things, the health status, claims experience, or a preexisting condition, of an applicant if the applicant satisfies designated criteria. Existing law provides an applicant for a Medicare supplement policy or contract with an open enrollment period in specified situations if the applicant, among other things, is at least 65 years old and was previously enrolled in Medicare.

This bill would expand eligibility for the guaranteed issuance of a Medicare supplement policy to include an individual enrolled in a Medicare+Choice plan if the plan reduces its benefits, increases the cost-sharing amount, or discontinues for other than good cause relating to the quality of care, a provider currently furnishing services to the individual. The bill would expand the ability of a qualified applicant to obtain a Medicare supplement policy or contract by, among other things, deleting the age requirement and expanding the open enrollment timeframe, as specified.

Because the bill would specify additional requirements with respect to the operation of a health care service plan, the violation of which would be punishable as a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1358.11 of the Health and Safety Code is amended to read:

1358.11. (a) An issuer shall not deny or condition the offering or effectiveness of any Medicare supplement contract available for sale in this state, nor discriminate in the pricing of a contract because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a contract that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement contract currently available from an issuer shall be made available to all applicants who qualify under this subdivision and are 65 years of age or older. Medicare supplement contracts A, B, C, F, and at least one letter-designated plan (H, I, or J, at the discretion of the issuer) that includes coverage for prescription medications, if currently available from an issuer, shall be made available to any applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have End-Stage Renal Disease. This section and Section 1358.12 do not prohibit an issuer in determining subscriber rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period

of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the director.

(c) Except as provided in subdivision (b) and Section 1358.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a contract, during the first six months, based on a preexisting condition for which the enrollee received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after he or she enrolled in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

There shall be a one-time open enrollment period of 90 days commencing on January 1, 2004, for all individuals eligible for Medicare by reason of disability who do not have End-Stage Renal Disease and who did not use the prior one-time open enrollment that commenced on January 1, 2001. Notice of this one-time open enrollment right shall be publicized on the Web sites of the Department of Managed Health Care, the Department of Insurance, and the Department of Aging, through those departments' written materials directed to Medicare beneficiaries, and by the Health Insurance Counseling Advisory Program (HICAP), beginning January 1, 2003.

(e) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(1) Receipt of a notice of termination or loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of termination or loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan. For purposes of this section, ''employer-sponsored retiree health plan'' includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included covered persons.

(2) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the issuer.

(g) (1) An individual whose coverage was terminated by a Medicare managed care plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare managed care plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage, with the exception of a Medicare Select contract, that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

SEC. 2. Section 1358.12 of the Health and Safety Code is amended to read:

1358.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement contract, eligible persons are those individuals described in subdivision (b) who apply to enroll under the contract not later than 63 days after the date of the termination of enrollment described in subdivision (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement contract.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement

contract described in subdivision (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of the Medicare supplement contract because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under the Medicare supplement contract.

(3) Issuers shall issue coverage with an effective date not later than the date of termination of previous benefits or the date requested on the application, but in no event earlier than the date of application for coverage. Issuers shall issue coverage so that there is no duplication or overlap of coverage.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, the individual loses his or her eligibility to continue benefits due to the divorce or death of a spouse, or the plan ceases to provide some, all, or substantially all of those supplemental health benefits to the individual and the employer no longer provides the individual with insurance that covers all of the payment for the Part B 20-percent coinsurance.

(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Medicare Part C, and any of the following apply:

(A) The organization's or plan's certification, under this part, has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(B) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856 of that act, or the plan is terminated for all individuals within a residence area.

(C) The individual demonstrates, in accordance with guidelines established by the director, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the

plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(D) The Medicare+Choice plan in which the individual is enrolled reduces any of the benefits under the plan or increases the cost-sharing amount or discontinues for other than good cause relating to the quality of care under the plan, a provider who is currently furnishing services to the individual. However, with respect to eligibility under this subparagraph, an individual shall be eligible only for a Medicare supplement contract issued by the same health care service plan through which the individual is enrolled at the time the reduction, increase, or discontinuance described above occurs. The change to another plan contract may occur no more frequently than every two years.

(E) The individual meets other exceptional conditions as the director may provide.

(3) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare risk or cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

(B) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of Section 1851(e)(4) of the federal Social Security Act as delineated in paragraph (2) of subdivision (b).

(4) The individual is enrolled under a Medicare supplement contract and the enrollment ceases because of the following: the insolvency of the issuer or bankruptcy of the nonissuer organization; the involuntary termination of coverage or enrollment under the contract; the issuer of the contract substantially violated a material provision of the contract; or the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the contract's provisions in marketing the contract to the individual.

(5) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement contract and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a

Medicare+Choice plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan), or a Medicare Select contract.

(B) The subsequent enrollment under subparagraph (A) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

(6) The individual, upon first becoming eligible for benefits under Medicare Part A who postpones enrollment in Medicare Part A or Part B while eligible for employer-sponsored coverage, enrolls in a Medicare+Choice plan under Medicare Part C, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(c) (1) Under paragraphs (1), (2), (3), and (4) of subdivision (b), eligible persons are entitled to a Medicare supplement contract that has a benefit package classified as plan A, B, C, F, and at least one letter-designated plan (H, I, or J, at the discretion of the issuer) that includes coverage for prescription medications, if currently available from an issuer.

(2) Under paragraph (5) of subdivision (b), eligible persons are entitled to the same Medicare supplement contract in which they were most recently previously enrolled, if available from the same issuer, or, if not so available, a contract described in paragraph (1) of subdivision (c).

(3) Under paragraph (6) of subdivision (b), eligible persons are entitled to any Medicare supplement contract offered by any issuer.

(d) (1) At the time of an event described in subdivision (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the contract, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement contracts under subdivision (a). That notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the contract, or the administrator of the plan, respectively, shall notify

the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement contracts under subdivision (a). That notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

(e) Issuers shall refund any unearned monthly premium paid in advance and terminate coverage upon the request of any insured person.

SEC. 3. Section 10192.11 of the Insurance Code is amended to read:

10192.11. (a) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and are 65 years of age or older. Medicare supplement contracts A, B, C, F, and at least one letter-designated plan (H, I, or J, at the discretion of the issuer) that includes coverage for prescription medications, if currently available from an issuer, shall be made available to any applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have End-Stage Renal Disease. This section and Section 10192.12 do not prohibit an issuer in determining premium rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification. This section shall not be construed as preventing the exclusion of benefits for preexisting conditions as defined in paragraph (1) of subdivision (a) of Section 10192.8.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the commissioner.

(c) Except as provided in subdivision (b) and Section 10192.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability will be entitled to open enrollment described in this section for six months after he or she enrolled in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility. Every issuer shall make available to every applicant qualified for open enrollment all policies and certificates offered by that issuer at the time of application. Issuers shall not discourage sales during the open enrollment period by any means, including the altering of the commission structure.

There shall be a one-time open enrollment period of 90 days commencing on January 1, 2004, for all individuals eligible for Medicare by reason of disability who do not have End-Stage Renal Disease and who did not use the prior one-time open enrollment that commenced on January 1, 2001. Notice of this one-time open enrollment right shall be publicized on the Web sites of the Department of Managed Health Care, the Department of Insurance, and the Department of Aging, through those departments' written materials directed to Medicare beneficiaries, and by HICAP, beginning January 1, 2003.

(e) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(1) Receipt of a notice of termination or loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of termination or loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan. For purposes of this section, ''employer-sponsored retiree health plan'' includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(2) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement

coverage but that coverage terminated because the individual established residence at a location not served by the plan.

(g) An individual whose coverage was terminated by a Medicare managed care plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement insurers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare managed care plan.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, with the exception of a Medicare Select policy, that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. An issuer shall notify a policyholder of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

SEC. 4. Section 10192.12 of the Insurance Code is amended to read:

10192.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement policy, eligible persons are those individuals described in subdivision (b) who apply to enroll under the policy not later than 63 days after the date of the termination of enrollment described in subdivision (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subdivision (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of that Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under that Medicare supplement policy.

(3) Issuers shall issue coverage with an effective date not later than the date of termination of previous benefits or the date requested on the application, but in no event earlier than the date of application for

coverage. Issuers shall issue coverage so that there is no duplication or overlap of coverage.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, the individual loses his or her eligibility to continue benefits due to the divorce or death of a spouse, or the plan ceases to provide some, all, or substantially all of those supplemental health benefits to the individual and the employer no longer provides the individual with insurance that covers all of the payment for the Part B 20-percent coinsurance.

(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan Medicare Part C, and any of the following apply:

(A) The organization's or plan's certification, under this part, has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(B) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856 of that act, or the plan is terminated for all individuals within a residence area.

(C) The individual demonstrates, in accordance with guidelines established by the commissioner, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(D) The Medicare+Choice plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost-sharing or discontinues for other than good cause relating to the quality of care under the plan, a provider who is currently furnishing services to the individual. However, with respect to eligibility under this subparagraph,

an individual shall be eligible only for a Medicare supplement policy issued by the same insurer through which the individual is enrolled at the time the reduction, increase, or discontinuance described above occurs. The change to another policy may occur no more frequently than every two years.

(E) The individual meets other exceptional conditions as the commissioner may provide.

(3) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare risk or cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

(B) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of Section 1851(e)(4) of the federal Social Security Act as delineated in paragraph (2) of subdivision (b).

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because of the following: the insolvency of the issuer or bankruptcy of the nonissuer organization; the involuntary termination of coverage or enrollment under the policy; the issuer of the policy substantially violated a material provision of the policy; or the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(5) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan), or a Medicare Select policy.

(B) The subsequent enrollment under subparagraph (A) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to

terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

(6) The individual, upon first becoming eligible for benefits under Medicare Part A who postpones enrollment in Medicare Part A or Part B while eligible for employer-sponsored coverage, enrolls in a Medicare+Choice plan under Medicare Part C, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(c) (1) Under paragraphs (1), (2), (3), and (4) of subdivision (b), eligible persons are entitled to a Medicare supplement policy that has a benefit package classified as plan A, B, C, F, and at least one letter-designated plan (H, I, or J, at the discretion of the issuer) that includes coverage for prescription medications, if currently available from an issuer.

(2) Under paragraph (5) of subdivision (b), eligible persons are entitled to the same Medicare supplement policy in which they were most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (1) of subdivision (c).

(3) Under paragraph (6) of subdivision (b), eligible persons are entitled to any Medicare supplement policy offered by any issuer.

(d) (1) At the time of an event described in subdivision (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subdivision (a). That notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subdivision (a). That notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

(e) Issuers shall refund any unearned monthly premium paid in advance and terminate coverage upon the request of any insured person.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates

a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O